“From Patient-hood To Personhood: Promoting and Advancing Recovery”

Presenter:
Cherene Allen-Caraco
Executive Director
Promise Resource Network
Much of what we have “learned” about mental health has come from trial and error. Throughout history, many factors have influenced our understanding of and therefore treatment of people with mental illness. These have included:

- religion
- gender
- culture
- class
- science
- technology
- geography
- war
- economics
- natural disasters
Another influence on the treatment of mental illness was and continues to be...

FEAR
“In the past, there was no such thing as mental illness, only madness. Its treatment was often indistinguishable from torture or murder.”

Dr. Thomas Pomeranz
## HISTORY OF MENTAL HEALTH

### CAUSES
Mental illness was thought to be caused by possession from the devil.

Evil Spirits were believed to enter and take over the body.

This demonic possession was seen as punishment for sin and as a result of anger from the gods.

### INFLUENCES
Beliefs were strongly influenced by religion, the lack of science and technology.

At the time, there was no division between medicine, magic and religion.

### TREATMENTS
Treatments varied depending on where one lived.

Shamans and witch doctors provided “treatment”

Trepanning was a common treatment
Trepanning

Types of this device have been used all over the world to release evil spirits or demons from a person’s head.

These instruments were used to drill holes in the skull to let the demons out!
# HISTORY OF MENTAL HEALTH

## The Renaissance Period

<table>
<thead>
<tr>
<th>CAUSES</th>
<th>INFLUENCES</th>
<th>TREATMENTS</th>
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<tbody>
<tr>
<td>People with mental illness were thought to be witches. This did not, however signal the end of demonology. It was widely believed that insanity was caused by possession of the devil, and a devil possessed a witch by copulation.</td>
<td>In part, as a result of the Church’s response to monks and nuns engaging in sexual activity, the theory of witchery arose.</td>
<td>Witch-hunts and physical punishments were in vogue.</td>
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<td>Also, a plague wiped out 1/3 of the population from India to Iceland. This included 50 percent of Europe’s population.</td>
<td>All witches were drowned or burned to make the body an “intolerable refuge for the devil,” a practice that was encouraged by “The Witch’s Hammer,” a witch hunters bible written by German monks.</td>
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<td>The reason attributed to the plague was punishment for sin.</td>
<td>Other treatments during this period included bloodlettings, purgatives, and eating roasted mice.</td>
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</table>
This technique involved taking large amounts of blood from the patient, leaving him/her depleted, exhausted, and obviously anemic. It was indicated for patients with a complete loss of reality in which such treatments caused a drop in blood pressure with resultant sedation.
### HISTORY OF MENTAL HEALTH

#### The 18th Century

<table>
<thead>
<tr>
<th><strong>CAUSES</strong></th>
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<tr>
<td>Shift from supernatural to more clinical view of mental illness.</td>
<td>Advances in science caused rejection of demonology and witchcraft.</td>
<td>Common “treatments” included chaining patients to walls, bleeding them, purging them, and swinging patients to “shake out” their madness.</td>
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- Physical causes of mental illness were being sought.
- Understanding of mental illness was linked to observations of animals. The thought was to make them obedient.
- Devices & methods like the straight jacket, the tranquilizer chair, cold water, cold air, forcing patients to stand erect for an extended period of time were believed to be wonderful “calming” methods.
Sensory Deprivation Device

A patient was strapped into this mechanism. The goal was to calm the patient by restricting his sensory input. This piece of equipment had several names.
In the late 18th century, German psychiatrist Johann Reil (1758-1813) invented this device. In theory, using this apparatus would bring about goal-directed behavior, with the hope that such activity on the patient's part would take him/her out of a hallucination-filled world and into reality.

Patients could spend 36-48 hours in the contraption and would then be ‘either well mannered and obedient or so tired by the constant pace that they presented little if any management problem.’

Hollow Wheel
<table>
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<tr>
<th><strong>CAUSES</strong></th>
<th><strong>INFLUENCES</strong></th>
<th><strong>TREATMENTS</strong></th>
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<tr>
<td>Mental illness was believed to be caused by either one’s biology or from society.</td>
<td>There was a great amount of fear due to the growing number of insane and their link to violence. More asylums were built, yet overcrowding persisted.</td>
<td>As conditions in the asylums steadily worsened, the need for treatment was overshadowed by the need for control.</td>
</tr>
<tr>
<td>Still, explanations such as intemperance, immorality, constipation, bee stings and attending socialist lectures persisted.</td>
<td>Sigmund Freud &amp; Josef Breur introduced theories relating to the study of the unconscious mind</td>
<td>As a result, restraints, shock therapy, ice water baths and expelling blood and vomit were seen as necessary.</td>
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<td>The end of the century saw the emergence of lobotomies.</td>
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</table>
This was an idea utilized during the 18th and 19th centuries based on the belief that a person's character could be learned. The individual mental abilities were believed to be contained in neat compartments and the size of these abilities was supposed to be reflected by a specific pattern. The best known model marked off the places of twenty-six separate organs.
This procedure was popularized in the United States when Walter Freeman invented the specifics of the process. From 1936 through the 1950’s, Dr. Freeman advocated this procedure throughout the United States. Such was Freeman's zeal that he began to travel around the nation in his own personal van demonstrating the procedure in many medical centers. He supposedly even performed a few in hotel rooms. Freeman's advocacy led to great popularity for this procedure as a general cure for all perceived ills, including misbehavior in children. It is said that an “assembly line” strategy was implemented in order to meet the needs of all the individuals who were to receive this form of treatment.
ECT (Electroconvulsive Shock Treatment)

This gadget claimed to be useful for certain patients with significant depression, especially those who had severe depression, or were at a high risk for suicide. This device allegedly worked by allowing a chemical release in the brain due to a controlled seizure.
The 20th Century

“No single group has undergone more widespread experimentation than the destitute mentally ill in state-run hospitals.”

Between 1939 and 1951 over 18,000 lobotomies were performed in the US.
What Is Culture?

**Webster's Definition:**

“the characteristic features of everyday existence [as... a way of life] shared by people in a place or time <southern *culture*>

the set of shared attitudes, values, goals, and practices that characterizes an institution or organization <a corporate *culture* focused on the bottom line>

the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic”

(Merriam-Webster On-Line Dictionary, 2009)
The Patient Identity:
The Culture of “Patienthood”
WHO AM I?

- Am I Bi-Polar?
- A schizophrenic?
- A patient, consumer and client?
- A mother/father
- A son/daughter
- A student

• A....... PERSON!?!
How Are People With Mental Illness Perceived By:

- The Community
- Service Providers
- Their Family
- Themselves
**Stigma:**

something judged by others as a mark of disgrace or shame and which can set one apart from everybody else.

**Self-Stigma:**

when a person begins to define or see themselves in a stigmatizing way. For example, when you are treated as incapable due to a mental health challenge, you may start to see yourself as incapable and begin to behave as though you are, relying on others to make all of your decisions for you.
An example of a Self-Stigmatizing identity is that of a patient. What does it mean to be a patient? How do you spend your time? Who is in control of your life? How does this impact what you think about yourself?
Who Am I?

“Patienthood”:

**Negative Sense of Self:**
- Shame, feeling unworthy, self loathing, fear, distrust of self,
- identity based on label/ diagnosis/symptoms,
- pessimism, invalidation, criticism, unwilling to take risks, lack of knowledge, information withheld

**Lack of Meaning and Purpose:**
- Being and accepting stagnancy
- Self absorption, helpless, hopeless
IMPACT OF “PATIENTHOOD”

Seeing yourself as a patient can mean seeing yourself as:

Helpless
In need of others to care for you
Dependent
Unable to make decisions
Broken
Incapable
Sick

And what does that do to your self-esteem? How does that affect your confidence, behaviors, thoughts, beliefs?
Have you ever wondered who you are? As a person, your beliefs, wants, likes, values? Trying to figure out who we are is common for all people.

When you have a mental health and/or addiction challenge, it could be even more important to discover your identity.

Do you think that sometimes you fall into the trap of seeing yourself or others as sick, broken or ill?

How can we, as peers and providers, recognize if someone else is seeing themselves through the lens of their diagnosis?

What could be the outward signs?
What can be their behavior, demeanor, things they say,
How do they present themselves, how do they spend their time, etc.

Let’s make a list...
The Culture of “Patienthood”

- Overuse of medications
- Deficits based
- Lack of voice, choice and ownership
- Viewed as incapable
- Alienation
- Forced treatment
“To Be A Mental Patient”

• To be a mental patient is to be stigmatized, ostracized, socialized, patronized, psychiatrized.

• To be a mental patient is not to matter.

• To be a mental patient is to wear a label, a label that never goes away, a label that says little about what you are and even less about who you are.

• To be a mental patient is to act glad when you're sad and calm when you're mad.

• To be a mental patient is to participate in stupid groups that call themselves therapy -- music isn't music, it's therapy; volleyball isn't a sport, it's therapy; sewing is therapy; washing dishes is therapy.

Rae Unzicker 6/84
Recovery: The Culture of “Personhood”

Healing Through Identity Development
There is a great deal of national, international and local interest regarding mental health recovery.

It is the subject of research, articles, books, system reform, measurement tools, training, advocacy efforts and program development.
Recovery is a personal journey of wellness, of living ones life despite having mental wellness challenges. Recovery means different things to different people. For some, Recovery is the result, for others, it is the process.
There exists, quite literally, hundreds of written, published, and unpublished accounts of people with serious mental illness or severe and persistent mental illness recovering.

These personal stories of Recovery have yielded much information on what Recovery is, how people Recover and ways to support and enhance Recovery.
What Is Recovery?

<table>
<thead>
<tr>
<th>Truth</th>
<th>Myth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery is a personal</td>
<td>Recovery is a cure or removal</td>
</tr>
<tr>
<td>journey of wellness, of</td>
<td>of symptoms and means no</td>
</tr>
<tr>
<td>living ones life despite</td>
<td>longer needing medications</td>
</tr>
<tr>
<td>having mental wellness</td>
<td>or support.</td>
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<tr>
<td>challenges, Recovery</td>
<td></td>
</tr>
<tr>
<td>means different things</td>
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<td></td>
</tr>
<tr>
<td>the process.</td>
<td></td>
</tr>
</tbody>
</table>
What Is Recovery?

Webster’s Definition:

“To Get Back: Regain” or “To Restore to A Normal State”

(Webster’s II New Riverside University Dictionary, 1984).
What Is Recovery?

Consumer’s Definitions...
Recovery Is...

“The reawakening of hope after despair”

“Moving from withdrawal to engagement and active participation in life”

“… an ongoing process of growth, discovery, and change”

“No longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self”

“… regaining belief in oneself”

“…is a continuing, deeply personal, individual effort that leads to growth, discovery and the change of attitudes, values, goals and perhaps roles”

“A journey from alienation to purpose”

“It is not accomplished alone— it involves support and partnership”

Recovery Is....

“No longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self”

United States DHHS—SAMHSA division convened 110 expert panelists who studied research, technical papers, reports, and their own experiences. The panel included consumers, families, providers, advocates, officials and representatives from seven Federal agencies:

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”
Where Did The Notion of Recovery come From?
Where Did Recovery Come From?

**Truth**

Recovery as a philosophy and model has been around for quite a while. It is based on research, that includes personal and professional accounts of Recovery. The data has yielded an understanding of:

- Outcomes (do people recover?)
- Definitions (what is recovery?)
- Models (what helps/hinders recovery?)
- Interventions, practices and techniques (evidence based and best practices)

**Myth**

Recovery is new. It is a fad, and unrealistic. Recovery was developed to diminish the cost of treatment.
There exists, quite literally, hundreds of written, published, and unpublished accounts of people with serious mental illness or severe and persistent mental illness recovering.

These personal stories of Recovery have yielded much information on what Recovery is, how people Recover and ways to support and enhance Recovery.
Where Did Recovery Come From?

1866
Elizabeth Packard

1908
Clifford Beers

1940’s
Mental Hygiene Movement

1949
Fountain House

1950’s
Thorazine and Deinstitutionalization

1970’s
Ex-Patient Movement/NAMI
"You can never change things by fighting the existing reality.

To change something, build a new model that makes the existing model obsolete."

buckminster fuller
The concept of Recovery emerged from consumers’ reaction to the treatment they received:

- overuse of medications
- lack of choice
- use of force
- focus on deficits and diagnoses

Beginning in the early 1980’s, personal accounts of mental wellness began to emerge. Initial “stories” of consumers’ journeys to wellness did not use the word “recovery,” rather, they opted for words such as well-being and mental wellness.
The word “Recovery,” as it related to mental illness, was first used in the late 1980’s in a consumer writing by Pat Deegan with “Recovery: The Lived Experience of Rehabilitation” and again in the early 1990’s in a non-consumer commentary, “Recovery from Mental Illness: the Guiding Vision of the Mental Health System in the 1990’s.”
The Emergence of the Recovery Model

“Consumers Speak”

As consumers talked.... professionals listened!

Consumers employed by systems management and involved in planning, policy making, program evaluations and service provision at the Offices of Consumer Affairs.

Consumers emerged as the experts, and were saying Recovery IS Possible!

To give a more credentialed voice to Recovery, consumers began obtaining their PhD’s, becoming therapists and psychiatrists.

Consumer-oriented research began and focused on Recovery.
Do People Recover From Mental Illness?

● Truth

Research supports that Recovery from mental illness is not a unique phenomena. When a recovery-orientation is utilized to support people, Recovery is enhanced.

● Myth

Recovery is possible for only a few select People with mental illness. People who have had lifelong symptoms and hospitalizations, can only expect stabilization.
Do People Recover From Mental Illness?

“Recovery research tells us that, given the right combination of attitudes and supports, people can fully recovery from mental illness.”

-Dan Fisher, MD, Ph.D.
Consumer, Psychiatrist and Advocate
Research on Recovery began 30-40 years ago.
Is Recovery Possible?  
Outcome Studies

Several studies have been conducted to determine the impact of a recovery philosophy on consumers’ well-being.

Harding and Colleagues (1987) The Vermont Study

A 32 year longitudinal outcome study on recovery and how it is impacted by mental health services.

Dr. Harding studied the success of a recovery oriented system in Vermont through a planned deinstitutionalization process, to a rehabilitation program with community supports. Subjects were then followed 32 years later.

Population studied

Most severely disabled bottom 19% in their state hospital.

Lifelong institutionalization; ill on average for 16 years, totally disabled for 10 years, continuously hospitalized for 6 years and most had been at the hospital for over 10 years.

No hope for Recovery; animal-like behavior
Results

• 62-68% fully recovered or significantly improved.

32 years later, 97% of the original 269 patients were involved in a follow up study:

• 34% of those people with a diagnosis of schizophrenia experienced full recovery in psychiatric status and social functioning.

• An additional 34% of the people who attended the rehabilitation program were significantly improved in both areas.

Of the 62-68%, half met all four of the recovery criteria, the other half met three out of four criteria, usually continuing to take medications while meeting the other criteria.

It should be noted that this cohort is the least functional ever studied.

Recovery was based on the following criteria:

• Having a social life indistinguishable from your neighbor (being integrated into the community)
• Holding a job for pay or volunteering
• Being symptom free (no current signs and symptoms of mental illness)
• Being off medication
<table>
<thead>
<tr>
<th>Study</th>
<th>Average Length in Years</th>
<th>Sample Size</th>
<th>Subjects Recovered and/or Improved Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. Bleuler (1972 a &amp; b) Burgholzli, Zurich</td>
<td>23</td>
<td>208</td>
<td>68%</td>
</tr>
<tr>
<td>Huber et al. (1975) Germany</td>
<td>22</td>
<td>502</td>
<td>57%</td>
</tr>
<tr>
<td>Ciompi &amp; Muller (1976) Lausanne Investigations</td>
<td>37</td>
<td>289</td>
<td>53%</td>
</tr>
<tr>
<td>Tsung et al. (1979) Iowa</td>
<td>35</td>
<td>186</td>
<td>46%</td>
</tr>
<tr>
<td>Harding et al. (1987 a &amp; b) Vermont</td>
<td>32</td>
<td>269</td>
<td>68%</td>
</tr>
<tr>
<td>Ogawa et al. (1987) Japan</td>
<td>22.5</td>
<td>140</td>
<td>57%</td>
</tr>
<tr>
<td>DeSisto et al. (1995 a &amp; b) Maine</td>
<td>35</td>
<td>269</td>
<td>49%</td>
</tr>
</tbody>
</table>

These are six other studies of a longitudinal nature, all over 20 years in length and demonstrating similar recovery rates. Recovery percentages are based on criteria similar to Dr. Harding’s definition, except for the Iowa study, which added marriage as a criterion.

(Center for the Study of Issues in Mental Health, 2003)
10 Fundamental Components of Recovery

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope
"Personhood":

Strong Self-Identity:
Self-advocacy, self-reliance, resourcefulness, identity, inner strivings, whole person, faith, personal responsibility, making decisions, information/education

Meaning and Purpose:
"a reason for being", goals, hopes, dreams
Recovery Highlights

- People with SPMI/SMI can and do Recover
- Recovery is not a cure or removal of symptoms. It is also not about symptom reduction, functioning and stabilization.
- Recovery is about “getting a life.” It is about self-awareness, an identity beyond that of “patient,” and personal accountability for your life. The specific definition of recovery varies and is defined by the person.
- Recovery is about partnership. It is not a hierarchical or paternal approach. Dignity of risk and informed decision making can be powerful wellness tools.
- There is room for both “traditional” and “non-traditional” interventions in recovery. It is about learning the most effective combination for you.
- Professional services can either help or hinder the recovery process.
- Peer support can be a valuable wellness approach. People with mental illness CAN work!
- Medications are one tool in recovery that can be effective. They do not, however, replace HARD WORK.
- Non-compliance does not exist in recovery. People must be active in their recovery and be encouraged to ask questions, become educated about their mental health and options, make decisions and accept responsibility for their decisions.
- Peer support is a valuable and effective approach to enhance recovery.
Supporting the shift from Patienthood to Personhood
ONE: Empathy and Awareness

Where does the stigma, negative perceptions and myths come from?
Major Factors Influencing Beliefs About Individuals with Mental Illness:

- Disparaging Language
- Jokes
- Stereotypes
- Diagnosis/Labels
- Misinformation
- Cultural Beliefs
- Media (TV, Movies, Music, Literature, Commercials, Newspapers, Magazines, News Reports...)
- Myths
- Stigma
The Service Provider Culture

- Authoritarian
- Ethics/Boundaries
- “Know what’s best”
- Decision makers
- “Mr/Mrs. Fix It”
- Safety and liability
The Influence of Labels and Diagnosis on Self-Identity

Advantages

- Qualify for funding
- Qualify for treatment
- May feel you are "not alone"
- Gives direction to treatment options
- Gives an understanding of symptoms

Disadvantages

- Stigma/Stereotypes
- Preconceived notions
- Self-fulfilling prophecy
- "One size fits all"
- Treated as a client, not person
- Behavior is explained only by diagnosis
WHAT CAN YOU DO TO SUPPORT PATIENTHOOD TO PERSONHOOD

How did you start to make the shift from seeing yourself or others as a person rather than patient?

What can you do to support others to make that shift?
What You Can Do To Promote Personhood:

Think and **behave** in a Person-Centered Way!

- Be aware of yourself
- Educate
- Use Recovery-Based Language
- Use a Strengths Perspective
- Be Empathic, Non-judgmental and Accepting
- Support Empowerment
The Other Side of the Desk

Have you ever thought just a wee little bit,
Of how it would seem to be a misfit,
And how you would feel if YOU had to sit,
On the other side of the desk?

Have you ever looked at the man who seemed a bum,
As he sat before you, nervous...dumb...
And thought of the courage it took to come,
To the other side of the desk?

Have you thought to yourself of his dreams that went astray,
Of the hard, real facts of his every day,
Of the things in his life that make him stay,
On the other side of the desk?

Have you thought to yourself, "It could be I,"
If the good things of life had passed me by,
And maybe I'd bluster and maybe I'd lie,
From the other side of the desk?

Did you make him feel he was full of greed,
Make him ashamed of his race or creed,
Or did you reach out to him in his need,
To the other side of the desk?

May God give us wisdom and lots of it,
And much compassion and plenty of grit,
So that we may be kinder to those who sit,
On the other side of the desk.
Anonymous
Empathy and Awareness

“A Positive Culture of Healing is one in which there exists an atmosphere of tolerance, empathy, compassion, respect, trust, cultural competence, inclusion, hope, and dignity.”

(What is Recovery? A Conceptual Model and Explication, 2001)
Recovery Based Language is language that:

1. Emphasizes the person, not their diagnosis (i.e. person with schizophrenia),
2. Recognizes the person’s strengths and abilities,
3. Promotes hope and possibility,
4. Helps people identify their challenges, needs and barriers as a part of their experience rather than labeling them as weaknesses, problems or deficits which imply that they are broken or their experience is abnormal.
Recovery-Based Language

The use of words that:

1. Promote Recovery and
2. Put the *person* first and their diagnosis or circumstances *last*.

**Words that promote Recovery include:**

* Hope    * Optimism * Success * Abilities
* Progress * Skills * Talents * Strengths

*Person-first language* ensures that individuals are identified based on their “*personhood*” not “*patienthood*.”
## Person-First Language

<table>
<thead>
<tr>
<th>Medical Language</th>
<th>Recovery Language</th>
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<tbody>
<tr>
<td>□ Deficits</td>
<td>□ Needs</td>
</tr>
<tr>
<td>□ “Schizophrenic”</td>
<td>□ “A person with Schizophrenia”</td>
</tr>
<tr>
<td>□ Problems</td>
<td>□ Challenges</td>
</tr>
<tr>
<td>□ “Medicaid Consumers”</td>
<td>□ “Individuals with Medicaid benefits”</td>
</tr>
<tr>
<td>□ Weaknesses</td>
<td>□ Barriers</td>
</tr>
</tbody>
</table>
THREE
Partnership: Giving Up Power and Control

“It is not our purpose to become each other; it is to recognize each other, to learn to see the other and honor him for what he is.”

---Hermann Hesse
PARTNERSHIP:

“You Lift me, And I’ll Lift you...
And We’ll Ascend together”

anonymous
Hi, I’m Robert
But, Robert is sooo sad!

“Seriously, I’m sad, my life sucks!”
“.... So I burned the pan and almost set the house on fire, honest mistake!”

“And I got lost going to my doctor’s appointment... Greensboro is a big city!”

“One more thing.... I love Maggie and if want to give her money, that’s my business...”
Dignity of Risk

The “dignity of risk” refers to the satisfaction of engaging in opportunities and new challenges that may entail an element of risk or may not be ‘advisable’ according to the dictates of others.
What Have You Risked?
Without Risk, Without Progress

The Mechanical Clock
The Printing Press
Immunizations and Antibiotics
The Automobile
Computers
The Photograph
Digital Video
Steel
Paper
Satellite Communications
Rubber

Modern Pluming
The Telephone
Electricity
Television
Recorded Sound
Moving Pictures
Concrete
Plastic
Nuclear Power
The Internet
Air Conditioning
To promote recovery, there must be a “positive culture of healing that includes mutuality, partnership and collaboration, listening and hearing the consumer’s perspective and upholding all of the consumers’ rights.”

(What is Recovery? A Conceptual Model and Explication, 2001)
Stigma is a reason people with mental health and addictive issues don’t get help. Don’t perpetuate the stigma through the use of language and correct others when you hear them using discriminatory or stigmatizing language. People with mental health issues are not “crazy,” “lunatics,” or “nuts.”

Being an advocate. Be an advocate- against inhumane, insensitive practices that demoralize or violate the rights of a person with mh/sas- use your voice!
Five: Promote Recovery Knowledge

Educate yourself and use that knowledge to change your practices:

Visit mental health programs especially advocacy groups
Learn about local resources
Attend trainings
Read books, articles, journals, etc.
SAMHSA Recovery To Practice Initiative

Focus Areas:
- American Psychiatric Association
- American Psychological Association
- American Psychiatric Nurses Association
- Council on Social Work Education
- National Association of Peer Specialists

Goals:
- Hasten awareness, acceptance, and adoption of recovery-based practices, approaches and model in the delivery of mental health services
- Further transform our mental health system to advance personal recovery
- Increase collaboration across disciplines
- Disseminate up to date research on evidence, evidence based and promising practice
The *Recovery to Practice* initiative includes two complementary components:

1) Creating a Recovery Resource Center for mental health professionals complete with Web-based and print materials, training, and technical assistance for professionals engaged in the transformation process; and

2) creating and disseminating recovery-oriented training materials for each of the major mental health professions. Through these two major components, the RTP initiative aims to foster a better understanding of recovery, recovery-oriented practices, and the roles of the various professions in promoting recovery.
SIX: Whole Health

The Eight Dimensions of Wellness

1. **EMOTIONAL**
   Coping effectively with life and creating satisfying relationships.

2. **ENVIRONMENTAL**
   Good health by occupying pleasant, stimulating environments that support well-being.

3. **INTELLECTUAL**
   Recognizing creative abilities and finding ways to expand knowledge and skills.

4. **PHYSICAL**
   Recognizing the need for physical activity, diet, sleep, and nutrition.

5. **FINANCIAL**
   Satisfaction with current and future financial situations.

6. **SOCIAL**
   Developing a sense of connection, belonging, and well-developed support system.

7. **SPIRITUAL**
   Expanding our sense of purpose and meaning in life.

8. **OCCUPATIONAL**
   Personal satisfaction and enrichment derived from one’s work.

WELLNESS
Seven: The POWER of Peer Support

“When people do not see “recovery” as part of their lives, they need to be surrounded with possibilities of recovery.”

A Person Fell in a Hole

A person experiencing emotional distress fell into a hole and couldn't get out. A businessman went by. The person in the hole called out for help. The businessman threw him some money and told him, "Get yourself a ladder." But the person could not find a ladder in this hole he was in.

A doctor walked by. The person said, "Help, I can't get out." The doctor gave him drugs and said, "Take this, it will relieve the pain," The person in the hole said thanks, but when the pills ran out, he was still stuck down there, all alone.

A renowned psychiatrist rode by and heard the person's cries for help. He stooped and said, "How did you get there? Were you born there? Were you put there by your parents? Tell me about yourself, it will alleviate your sense of loneliness." So the person talked with him for fifty minutes, then the psychiatrist had to leave, but he said he'd be back next week. The person thanked him, but was still in his hole.

A priest came by. Again, the person in the hole called out for help. The priest gave him a Bible and said I'll say a prayer for you. He got down on his knees and prayed, then left. The person was grateful; he read the Bible, but he was still stuck in that hole.

A Peer Mentor happened to be passing by. The person cried out, "Hey, help me, I'm stuck in this hole." Right away, the Peer Mentor jumped in the hole with him. The person in the hole said, "What are you doing? Now we're both stuck here." But the Peer Mentor said, "It's okay, I've been here before, and I know how to get out."
Eight: Employment is a PATH to Recovery

about 85%
Say that they **want** to work.
References

